

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2984SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/10/2009
NAME OF PROVIDER OR SUPPLIER NEVADA STATE VETERANS HOME - BOULDER CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 100 VETERANS MEMORIAL DR BOULDER CITY, NV 89005		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	<p>Initial Comments</p> <p>Surveyor: 26907</p> <p>This Statement of Deficiencies was generated as the result of a State licensure survey conducted on November 3, 2009 through November 10, 2009, in accordance with Nevada Administrative Code, Chapter 449, Skilled Nursing Facilities. The survey was conducted concurrently with the Medicare recertification survey.</p> <p>The census at the time of the survey was 165. The sample size was 25 including 3 closed records.</p> <p>A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.</p> <p>Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p>	Z 000		
Z230 SS=G	<p>NAC 449.74469 Standards of Care</p> <p>A facility for skilled nursing shall provide to each patient in the facility the services and treatment that are necessary to attain and maintain the patient's highest practicable physical, mental and psychosocial well-being, in accordance with the</p>	Z230		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2984SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/10/2009
NAME OF PROVIDER OR SUPPLIER NEVADA STATE VETERANS HOME - BOULDER CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 100 VETERANS MEMORIAL DR BOULDER CITY, NV 89005		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z230	<p>Continued From page 1</p> <p>comprehensive assessment conducted pursuant to NAC 449.74433 and the plan of care developed pursuant to NAC 449.74439.</p> <p>This Regulation is not met as evidenced by: Surveyor: 13766</p> <p>Based on observation, interviews and record review, the facility failed to ensure that one resident was given the protective supervision needed to prevent an accident with injury from occurring (Resident #25).</p> <p>Findings include:</p> <p>Resident #25</p> <p>Resident #25 was an 84 year old male admitted to the facility on 4/29/09, with diagnoses to include Dementia of Alzheimer's Type, Hypertension, Anxiety State, Memory Loss, and Prostate Neoplasm.</p> <p>The Discharge Summary from the facility dated (date dictated unknown), for Resident #25 documented the following:</p> <p>"This is an 84 year old gentleman being treated at the (facility's name) for dementia of the Alzheimer's type, hypertension, hyperlipidemia, anxiety disorder, prostate neoplasm. On 10/14/09, the patient had an unfortunate fall on the patio adjoining the main cafeteria in the Mariner Unit. The patient believed he was playing with his grandchildren in the early morning hours of October 14, 2009, subsequently he fell, striking his head on the pavement and lacerating his forehead and injuring other areas of his face. The patient was subsequently sent to (facility</p>	Z230		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2984SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/10/2009
NAME OF PROVIDER OR SUPPLIER NEVADA STATE VETERANS HOME - BOULDER CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 100 VETERANS MEMORIAL DR BOULDER CITY, NV 89005		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Z230	<p>Continued From page 2</p> <p>name) for further evaluation and care and treatment. The patient was subsequently sent to (facility name in Las Vegas) for further care and treatment upon which the patient subsequently passed..."</p> <p>The Emergency Transfer form for Resident #25 dated 10/14/09 (no time) documented, "reason for transfer resident fell sustaining injuries to head and hands C/O (complaining of) neck pain. Mental Status Confused"</p> <p>On 4/22/09, a Questionnaire on Behavioral Concerns & Psychiatric History documented, "1. Wandering...getting lost-concern just in the last two weeks."</p> <p>The Care Plan for Resident #25 documented on 4/30/09, and reviewed and initialed on 7/30/09 revealed, "Memory (name of resident) is very forgetful he has memory loss and has potential for increase in confusion. cognitive loss; he has no dx (diagnosis) of dementia or Alzheimer's) 7/30/09 able to find his room and other common areas. Able to make needs known. Has episodes of disorientation."</p> <p>Resident #25's History and Physical, dated 4/29/09, indicated the resident was admitted to the facility due to the resident no longer able to care for himself at home. The note indicated the resident had been picked up by the police wandering on one occasion.</p> <p>A Psychiatric Evaluation for Resident #25, dated 5/1/09, documented the following, "The patient was alert and oriented to person only...His memory for recent events was significantly impaired...His judgement of self-preservation may be impaired by his memory difficulties...His</p>	Z230			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2984SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/10/2009
NAME OF PROVIDER OR SUPPLIER NEVADA STATE VETERANS HOME - BOULDER CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 100 VETERANS MEMORIAL DR BOULDER CITY, NV 89005		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Z230	<p>Continued From page 3</p> <p>insight in his current situation is poor to fair."</p> <p>A Psychological Evaluation for Resident #25, dated 5/14/09, documented, "...Although the patient was alert and oriented to the year and month, he was unable to accurately recall the day of the week or date...The patient was quite verbal, interactive but had great difficulty responding directly to the questions...when asked yes or no the patient tended to give long confusing and tangential answers...Although the patient was initially placed on the Falconer unit, he had a physical altercation with his roommate and had difficulty adhering to the restraints of his room. In other words the patient tended to move in and out of the patient's room and needed to be constantly redirected. Based on these earlier problems the patient was placed in the cove for further assessment to help him adjust to the facility.</p> <p>A Physician's Telephone Order for Resident #25, dated 5/20/09, documented, "Place watchmate and monitor daily."</p> <p>A Nurse's Note, dated 5/21/09 at 6:30 PM, Resident #25 during an outdoor barbecue Resident #25 went through the activity staff's cart found a concealed scissor and cut off his wanderguard from his ankle. The notes indicated it was replaced on the resident's wrist.</p> <p>A Progress Note, dated 6/12/09 for Resident #25, documented the following, "...The Patient was becoming agitated and restless and being in the locked unit after consultation with staff and his doctors they agreed to transfer the patient to the regular Mariner unit...The patient continued to have difficulty recalling individual visits with this writer and has problems incorporating new</p>	Z230			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2984SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/10/2009
NAME OF PROVIDER OR SUPPLIER NEVADA STATE VETERANS HOME - BOULDER CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 100 VETERANS MEMORIAL DR BOULDER CITY, NV 89005		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Z230	Continued From page 4 information...The patient has shown no signs of aggressive behavior which was evident during his first week at the facility..." Nurse's Notes for Resident #25, dated 7/8/09, indicated the resident was sent to the hospital after an altercation with another resident. The notes indicated Resident #25 had fractured ribs and a laceration to the head. Severity 3 Scope 1	Z230			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.